NOTIFICATION OF COMPLETION AND REQUEST FOR APPROVAL FOR OUT-OF-STATE DUI EDUCATION COURSE

Client's Name		DOB:	
Driver's License Number			
Address			
City, State, ZIP			
Telephone		Fax	
Email			

To comply with Montana statute (61-8-732) and administrative rules (37-27-506, 37-27-516 & 37-27-525), the ACT DUI Education Course must:

- **be at least 8 hours in duration**
- **review MT DUI laws and consequences of violating them (http://leg.mt.gov/bills/mca/61/8/61-8-714.htm)**
- **review physiological and neurophysiological effects of alcohol and other drugs**
- **review social and psychological implications of alcohol and other drug use**
- **complete a self-assessment**

I certify that:

1. My name is _____.
2. I am a certified or licensed counselor in the State of _____ to complete alcohol/drug education and treatment. My certification or license number is _____.
3. This client completed the following:

   ☐ An ACT DUI education program that includes a minimum of eight hours of education..

   ☐ A substance use disorder / chemical dependency assessment completed by a certified or licensed counselor in that state to do such assessments.

4. The following requirements were met:

   ☐ A diagnosis was made based on DSM-IV/V

   ☐ The client was referred for chemical dependency treatment. **NOTICE: For second and subsequent DUI convictions, treatment is mandatory.**

   ☐ Treatment will be provided by _____

   Agency / Program City State

I declare under penalty of perjury and under the laws of the State of Montana that the information in this document is true and correct. I understand that it is a crime to give false information in this document.

Date: _____ City _____ State _____Counselor's Signature: _____

Please include the following documents with this form:

1. A copy of addiction counselor certificate / license.
2. Course agenda with date and times to verify length of course in hours.
3. Verification of course content: this can be provided by a copy of the Table of Contents, Outline of Course, or copy of curriculum.

Return this form and the attachments to:

Chemical Dependency Bureau
Addictive and Mental Disorder Division
MT Dept. Public Health and Human Services
PO Box 202905
100 N. Park Avenue, Suite 300
Helena, MT 59620-2905
Fax: 406-444-4435

For DPHHS Chemical Dependency Bureau to complete:

ACT DUI Education Course _____ approved _____ not approved
If not approved, reason: _____
Date: _____ Signature of Reviewer:_____
Printed Name and Title: _____
Date forwarded to Montana Vehicle Division, Drivers Services Bureau_____ DSB Fax 444-1631